



NFIB RESEARCH FOUNDATION

Testimony of

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Thank you, Mr. Chairman.

I will summarize and ask that my complete testimony, including attachments, be entered into the record. I have also provided the subcommittee a rather lengthy study on steps to control rising healthcare costs prepared for the NFIB Research Foundation by Professor Louis F. Rossiter at William & Mary. Since the study is publicly available on the Research Foundation page of the NFIB Web site, I do not request its inclusion in the record. However, its concluding recommendations have been incorporated in my testimony as an attachment.

Mr. Chairman, I will direct my remarks to two issues – the employer mandate and the importance of cost control in healthcare reforms.

Employer mandates (offer and fund) to provide employee health insurance, or their equivalents pay or play and payroll taxes, are bad for small employers, bad for the low-income, and bad for the economy. They adversely affect small employers because they raise payroll costs, erode competitive positions, and increase start-up costs, making it particularly difficult for less profitable firms and those operating on small margins. Employer mandates adversely affect the low-income because they result in lost employment, depressed wages, and other unfortunate impacts, such as the lost work hours, for employees in general, but for the low-income in particular. They adversely affect the economy because they effectively levy a regressive payroll tax on the businesses and people least able to afford it.

The fallout from mandates, described above, is generally not in dispute. Only the details are, including the relative value of effectively taxing the low income to pay for their own health insurance, in a hidden way, that grabs the pool of “employer?” money on the vis-à-vis subsidizing coverage of the low income with transparent, but politically more difficult, funding.¹ Overlooked typically is the associated point that small employers who do not offer employee health insurance tend to be those operating marginally profitable businesses and businesses with low margins. There is great variation in the income/earnings that owners take from their firms and I previously have reported a direct relationship between owner income extracted from a business and the provision of employee health insurance.² Similarly, recent research conducted for the NFIB Research Foundation by a group at George Mason University, associated with Nobel Prize winner Vernon Smith, found a relationship between provision of health insurance under various mandate scenarios and profit margin regardless of firm size.³ It was a finding not originally hypothesized or sought, but one that fell out of the data.

The attached paper, “The Case Against Mandated Employer-Provided Employee Health Insurance: A Small Business Perspective” delves into much greater detail about these issues from the perspective of small business owners. While the paper is well-documented, it focuses on the trade-offs and decisions small employers face under conditions of a mandate. And, then it follows with consequences of the adjustments they must make to comply with government requirements and market demands.

Recent rumblings suggest small employers may have changed their traditional opposition to employer health insurance mandates.⁴ Let me settle the point once and for all. Small employers have not changed their collective views on the issue. A telephone survey of

¹ An articulate summary of the idea’s implications for healthcare reform appear in Ezekiel J. Emanuel and Victor R. Fuchs, “Who Really Pays for Healthcare? The Myth of “Shared Responsibility”, *JAMA*, Vol. 299, No. 9, March, 2008, p. 1057. It reads in part,

Employers do not bear the cost of employment-based insurance; workers and households pay for health insurance through lower wages and higher prices. Moreover, government has no source of funds other than taxes or borrowing to pay for healthcare.

Failure to understand that individuals and households actually foot the entire healthcare bill perpetuates the idea that people get great health benefits paid for by someone else. It leads to perverse and counterproductive ideas regarding healthcare reform.

² William J. Dennis, Jr., “Wages, Health Insurance, and Pension Plans: The Relationship Between Employee Compensation and Small Business Owner Income,” *Small Business Economics*, Vol. 15, No. 4, December, 2000, p.227.

³ Stephen Rassenti and Carl Johnston, *Health Insurance Reform in an Experimental Market*, NFIB Research Foundation, Washington, 2009.

⁴ For example, the Robert Wood Johnson Foundation conducted a survey of small business owners (released December 2008) that suggested small business owners are split on the issue. Unfortunately, the survey sampled only those with insurance, worded the question so those with insurance received a tax credit, and got a bare majority. In other words, half of small employers were omitted from the sampling frame, the ones most likely to oppose the mandate; the question included provision of a tax credit which meant everyone sampled would gain and no one would lose; and, it applied only to those with 10 employees or more. A similar pay or play proposal came in dead last as an idea that would help their smaller firm most.

1,000 small employers conducted for the NFIB Research Foundation by Mason-Dixon in December and January show 80 percent opposition. To determine whether NFIB member employers varied from the broader small employer population, the survey took 500 from each. As the appended graph shows, there is no statistical difference between the two. Both groups overwhelmingly oppose a mandate.

My second point is the critical position of healthcare costs in depressing health insurance coverage and making care affordable to many covered Americans. There is no dispute on this point, either. Yet, its discussion typically warps into questions of coverage, ignoring the proposition that much of the coverage problem originates with the cost problem. Hence, we continue to put serious consideration of coverage before serious consideration of cost. If that sequence becomes law, the healthcare system will be swamped with additional demand (assuming the uninsured are underserved) with little or no provision for curbing costs. That will only push costs higher, further straining the budgets of those who ultimately pay for it.

Blue Cross/Blue Shield reports that between 2005 and 2007, healthcare expenditures in Massachusetts rose from \$20.8 billion to \$25.5.⁵ The associated percentage decline in the uninsured is uncertain, subject to survey and statistical issues,⁶ but the number of uninsured has gone down by perhaps half from a low base. The number of newly insured is therefore comparatively small. The new demand, added to a sophisticated healthcare delivery system in a geographically compact state, with comparatively few illegal immigrants, and a population among the most covered in the country, was associated with health expenditure increases of 23 percent. National per capita numbers rose 11 percent in the same period.⁷ The principal visible difference in the time span is new demand brought about by the Massachusetts experiment without accompanying cost-depressing measures. Imagine the parallel in states without those advantages.

Attacking costs cannot be a political throwaway line. It must be real and the first order of business in healthcare reform. To do otherwise would jeopardize everyone's healthcare.

Thank you, Mr. Chairman. NFIB looks forward to working with you on resolution of the critical healthcare issues we face.

⁵ Robert Seifert and Paul Swoboda, *Shared Responsibility: Government, Business, and Individuals: Who Pays for What Health Reform?* Blue Cross Blue Shield Foundation of Massachusetts Foundation, 2009, p. 8.

⁶ Sharon Long, et al., *Estimates of the Uninsured Rate in Massachusetts from Survey Data: Why are They So Different?* Massachusetts Division of Healthcare Finance and Policy, Boston, 2008

⁷ Kaiser Family Foundation. <http://facts.kff.org/Chart.aspx?ch=854>